South Carolina Department of Health
and Environmental Control

The South Carolina Suicide Prevention Plan

June 2005

South Carolina Suicide Prevention Task Force

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Dear Citizens of South Carolina:

In the fall of 2003, the Office of the Secretary of the Department of Health and Human Services identified the South Carolina Department of Health and Environmental Control (DHEC) as the lead state agency to begin to examine the issue of suicide and suicide prevention in the state. In response to this charge and with concern for those who are impacted by this serious public health issue, a small group of committed and concerned professionals and citizens were identified to begin this process. This dedicated group came together to form the first ever South Carolina Suicide Prevention Task Force.

The primary goals of the Task Force were to create an increased awareness about this serious public health issue and to develop a plan and/or guide for the state. Their hard work over the past months has culminated in the following document. This document helps to align South Carolina with the National Strategy to Prevent Suicide that was released in 2001 by the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMSHA) and Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services.

DHEC and the Task Force recognize the critical importance of individual survivors and survivor groups to this effort. Their passion and commitment pushed the nation to recognize the need for collective action and their continued involvement is imperative. This involvement supports our core value of seeking local solutions to local problems. As Commissioner of the state's Public Health agency, I support the goals and objectives put forth in this document. It provides a guide for us to work together in public-private collaborations to address this critical public health issue.

Sincerely,

C. Earl Hunter
Commissioner

/rlc

Executive Summary

Suicide continues to be a major public health problem internationally, nationally and in South Carolina. The World Health Organization (WHO) reports that suicide accounts for almost half of all violent deaths worldwide... This results in almost one million preventable fatalities every year, as well as economic losses in the billions of dollars. According to the WHO Assistant-Director General, "more people die from suicide than from all homicides and wars combined." In the United States over 31,000 deaths annually are attributed to suicide. The human and financial costs of suicide are significant in South Carolina. Every day in South Carolina there is at least one reported death by suicide, and unknown numbers of suicides that are attributed to other causes. There are scores of suicide attempts resulting in injury and incalculable financial and emotional losses.

A number of complex individual, social, and environmental factors contribute to suicide and suicidal behavior. Among these are poverty, unemployment, loss of a loved one, failed relationships, alcohol and other drug abuse, social isolation, mental disorders, and easy availability of and access to lethal means, including the most common method in South Carolina, firearms. To effectively address this devastating suffering and loss of human life, long term, multi-pronged approaches, including both interventions and primary prevention strategies, must be put into place.

South Carolina is committed to responding to this growing public health issue. The formation of the South Carolina Suicide Prevention Task Force was a first step in promoting a collaborative statewide effort. The following plan or strategy is not meant to be a state mandate, but to serve as our own "call to action" and a guide for interested individuals and groups. South Carolina joins the national efforts by putting forth this document. The ultimate goal of this report and the Task Force is to promote the improved health and safety of all South Carolina citizens.

Although all eleven goals of the National Strategy, as referenced in the body of the plan, are important, the Task Force selected the following two goals as the primary focus of their efforts:

- *Promote awareness that suicide is a public health problem that is preventable.*
- *Develop broad-based support for suicide prevention, including the formation of a broad statewide coalition.*

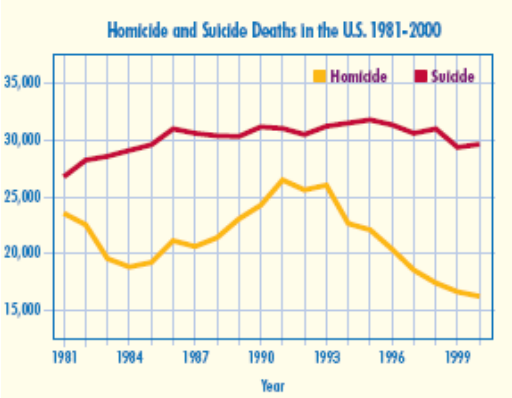
State and local agencies, organizations and communities are encouraged to create action steps and identify which of the eleven goals and objectives address their own organizational and community needs.

Suicide: Cost to the Nation

> *The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.*
>
> *Kay Redfield Jamison*

Every year more Americans take their own lives than are killed in homicides – an average of one life lost every 17 minutes. Approximately 600,000 people attempt suicide each year. In the past two decades, the rate of suicide among 10-14 year-olds has nearly doubled. Suicide affects all of us. The trauma can impact entire families and communities.

Family members may blame themselves, adding to their pain. The annual economic and social loss to society is estimated to be in the billions of dollars. (American Association of Suicidology)



Suicide: Cost to the Nation

- Every 17 minutes another life is lost to suicide.
- Every day 87 Americans take their own lives and over 1500 attempt suicide.
- Suicide is now the eleventh leading cause of death in America.
- For every two victims of homicide in the U.S., there are three deaths from suicide.
- There are now twice as many deaths due to suicide than due to HIV/AIDS.
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.
- In the month prior to their suicide, 75% of elderly persons had visited a physician.
- Over half of all suicides occur in adult men, aged 25-65.
- Elderly adults have rates close to 50% higher than that of the nation as a whole (all ages)
- Males are four times more likely to die from suicide than are females.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.
- Suicide takes the lives of more than 31,000 Americans every year.

National Strategy for Suicide Prevention, 2001
American Association of Suicidology, 2002

National Call to Action

In 1999, the Surgeon General released his "Call to Action To Prevent Suicide". This report highlighted a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). The Surgeon General recommended that each state adopt a suicide prevention plan. The "National Strategy for Suicide Prevention: Goals and Objectives for Action." was released in 2001. This report described suicide as a serious public health problem throughout the United States and included national recommendations.

National Strategy for Suicide Prevention

The National Strategy for Suicide Prevention was developed by the Department of Health and Human Services under the direction of the Substance Abuse and Mental Health Services Administration, and the Office of the Surgeon General; and through the partnership and collaboration of stakeholders in the public and private sectors.

The National Strategy is designed to be a catalyst for social change, with the power to transform attitudes, policies, and services. The effective implementation of the National Strategy will play a critical role in reaching the suicide prevention goals outlined in the nation's public health agenda, Healthy People 2010.

KEY ELEMENTS OF A PLANNED NATIONAL STRATEGY

A national strategy for the prevention of suicide has many interrelated elements contributing to success in reducing the toll from suicide.

- A means of engaging a broad and diverse group of partners to develop and implement the national strategy with the support of public and private social policies.
- A sustainable and functional operating structure for partners with authority, funding, responsibility, and accountability for national strategy development and implementation.
- Agreements among federal agencies and institutions outlining and coordinating their appropriate segments of the national strategy.
- A summary of the scope of the problem and consensus on prevention priorities; for example, **The Surgeon General's Call to Action to Prevent Suicide 1999** (USPHS, 1999).
- Specified national strategy aims, goals, and measurable objectives integrated into a conceptual framework for suicide prevention.
- Appropriate, measurable activities for practitioners, policy makers, service providers, communities, families, agencies, and other partners.
- A data collection and evaluation system to tract information on suicide prevention and benchmarks for national strategy progress.

National Strategy for Suicide Prevention Goals

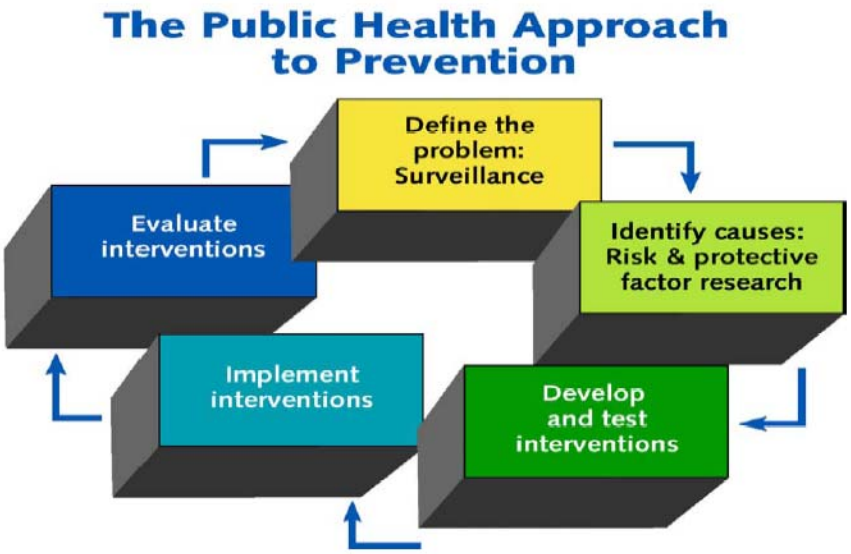
1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Develop and implement community-based suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Increase access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

The Public Health Approach to Address Suicide Prevention

> *Suicide is a public health problem that requires an evidenced-based approach to prevention. In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying and understanding the patterns of suicide and suicidal behavior throughout a group or population. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities.*
>
> *The Surgeon General's Call to Action to Prevent Suicide, 1999*

The National Strategy for Suicide Prevention advocates a public health approach to suicide prevention. Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.

The public health approach is widely regarded as the approach that is mostly likely to produce significant and sustained reductions in suicide. It uses five basic evidence-based steps in a systematic way. These steps are applicable to any public health issue that threatens substantial portions of a group or population.



The steps may be sequential or overlapping. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. A built-in evaluation component is essential for identifying best practices and guiding the development of new interventions.

Risk and Protective Factors for Suicide

Risk factors increase the potential for suicide and suicidal behavior. Protective factors serve as a "buffer" or counterbalance to risk factors and reduce the likelihood of suicide or suicidal behavior. Risk and protective factors may be biopsychosocial, environmental or sociocultural in nature. Understanding the interactive relationship between risk and protective factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention (Móscicki, 1997). Unfortunately, the scientific studies that demonstrate the suicide prevention effect of altering specific risk or protective factors remain limited in number.

However, the impact of some risk factors can clearly be reduced by certain interventions such as providing psychotropic medication for bipolar disorder or strengthening social support in a community (Baldessarini, Tando, & Hennen, 1999). Risk factors that cannot be changed, such as a previous suicide attempt, can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder or following a significant stressful life event (Oquendo et al., 1999). Protective factors are quite varied and include an individual's attitudinal and behavioral characteristics as well as attributes of the environment and culture (Plutchik & Van Praag, 1994). The following risk and protective factors are identified in the National Strategy. For Suicide Prevention: Goals and Objectives.

Protective Factors for Suicide

Protective Factors for Suicide

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Risk Factors for Suicide

Risk Factors for Suicide

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Information about risk and protective factors for attempted suicide is more limited than that on suicide. One problem in studying non-lethal suicidal behaviors is a lack of consensus about what actually constitutes suicidal behavior (O'Carroll et al., 1996). Should self-injurious behavior in which there is no intent to die be classified as suicidal behavior? If intent defines suicidal behavior, how is it possible to quantify a person's intent to die? The lack of agreement on such issues makes valid research difficult to conduct. As a result, it is not yet possible to say with certainty that risk and protective factors for suicide and non-lethal forms of self-injury are the same. Some authors argue that they are, whereas others accentuate differences (Duberstein et al., 2000; Linehan, 1986).

Suicide in South Carolina

According to the Centers for Disease Control and Prevention (CDC), suicide is the 2nd leading cause of injury death in South Carolina. The state's rate from 1999-2003 per 100,000 population is 11.3, exceeding the national average 10.7. According to Vital Statistics data available from the South Carolina Department of Health and Environmental Control, Office of Public Health Statistics and Information Services, suicide rates have increased from 1999 to 2003. The overall suicide rate in South Carolina rate has increased from 10.7 to 11.3 during this time period. The male rate of suicide increased from 18.2 in 1999 to 19.0 in 2003. Female suicide is also increasing from a rate of 4.1 in 1999 to 4.9 in 2003. Suicide rates have increased for white (13.2 in 1999 to 14.6 in 2003) and African American (4.2 in 1999 to 5.3 in 2003) South Carolinians. The suicide rate for white females in S.C. has risen slightly from 6.4 in 2000 to 6.7 in 2003. The number of African American female suicides is too small for meaningful rate comparison. White and African American male suicide rates have risen.

African American males completed suicide at a rate of 10.3 in 2000 and 10.7 in 2003. White males complete suicide at the highest rates, from 21.9 in 2000 to 23.2 in 2003.

The male rate of suicide increased from 18.2 in 1999 to 19.0 in 2003. Though the highest numbers of suicide are among the 35-44 years of age, the highest rate is among the elderly ages 75 and older. In that age group, the 1999-2003 suicide rate is 17.5. This is the highest rate, with the 35-44 year age group following at 17.3.

Overwhelmingly, firearms are the most commonly used method to commit suicide in S.C. From 2000-2003, 66.9% of all suicides were completed through the use of firearms. According to CDC data from 1999-2002, this trend remains for both sexes, races and age groups, except children 10-14 years of age. Suffocation (61.9%) is the most common method for the 10-14 year age group. The extent and character of suicide cannot be determined by death alone. Injury information about suicide attempts from hospital emergency room visits and inpatient care provides an added layer of understanding. Data from these sources provided by the S.C. Budget and Control Board, Office of Research and Statistics (ORS) shows that females commit the greatest number of suicide attempts, although completed suicides are less common than in men. Poisoning is the most commonly-used method by women attempting suicide nationally.

Death Statistics for Residents of South Carolina
Cause of Death: Suicide (Intentional Self-Harm)
Year

	1999		2000		2001		2002		2003		1999-2003	
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1 to 14	8	1.1	5	0.6	3	0.4	6	0.8	3	0.4	25	0.6
15 to 24	64	11.5	48	8.3	53	9.1	49	8.2	45	7.5	259	8.9
25 to 34	61	10.9	68	12.1	92	16.2	75	13.2	81	14.5	377	13.4
35 to 44	96	15.3	93	14.9	108	17.1	122	19.4	121	19.8	540	17.3
45 to 54	65	12.4	99	18	96	17.2	83	14.2	92	15.8	435	15.5
55 to 64	60	17.2	49	13.1	62	16.4	51	12.3	60	13.9	282	14.5
65 plus	65	13.7	83	17.1	59	12	80	15.9	94	18.4	381	15.5
75 to 84	24	15.1	33	20	26	15.6	31	17.9	40	22.9	154	18.4
75 plus	31	15.1	47	21.8	30	13.8	38	16.6	47	20.2	193	17.5
85 plus	7	15	14	27.9	4	7.9	7	12.7	7	12	39	14.9
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
All ages	419	10.7	445	11.1	473	11.6	466	11.2	496	12	2,299	11.3

Rates per 100,000
Fates for all ages are age adjusted. Others are age group specific.
Age adjustments uses 2000 Standard Population
Footnote
Rates calculated with small numbers are unreliable and should be used cautiously.

Chart source: SCAN (http://scangis.dhec.sc.gov/scan/) - from the Division of Biostatistics and Health GIS.

Vulnerable Populations

Youth

While the total number of completed suicides is relatively low for South Carolina teens, the number of attempts and the number of youth who self-report feeling suicidal continues to raise concerns for the state. According to the*2003 South Carolina Youth Risk Behavior Survey 15.4 % of all South Carolina high school teens have seriously considered suicide as an option and 13.5% have made a suicide plan. Males are 4 times more likely to die from suicide given the more lethal means selected, while females are more likely to make suicide attempts. Research indicates that substance abuse and/or alcohol abuse significantly increases the risk of suicide in young people. (*unweighted data)

Middle Age

According to data provided by the National Suicide Prevention Resource Center and DHEC's Office of Public Health Statistics and Information Services, the highest numbers of suicide deaths in South Carolina are in the 25-44 year old group. 41% of all completed suicides occur in this population. Men in this age group are particularly vulnerable because of their choice of more violent, lethal means and a tendency not to seek assistance.

Elderly

Older citizens experience higher rates of suicide due in part to the prevalence of multiple risk factors, including major physical illness, social isolation, and lack of support. This group has the highest rate in South Carolina with a rate of 17.5 per 100,000 for those 75 years old and older. As the general population ages across the nation and in South Carolina, and as more retirees relocate to South Carolina, this group may require additional attention.

African Americans in South Carolina

Epidemiologists have observed an increase in suicide unparalleled by other ethnic groups in the U.S. There is no clear understanding of the social or cultural phenomena that may account for the already low suicide rate and the recent increase in suicide deaths among African American men. S.C. has seen a significant increase in the rate of high school aged males who report contemplating suicide from * 6.7 in 2001 to *8.4 in 2003. African American males also were more likely to attempt suicide once *9.3% vs. *7.0% overall. The Task Force expressed particular concern about the rate increases in this population. (*unweighted data, Youth Risk Behavior Survey)

South Carolina Violent Death Reporting System

Vital statistics provide valuable data regarding the demographics of suicide victims but do not provide information regarding the when, where, how and why suicide occurs. The Division of Injury and Violence Prevention at SC DHEC, houses the South Carolina Violent Death Reporting System (SCVDRS). SCVDRS is part of the National Violent Death Reporting System and is funded by the Centers for Disease Control and Prevention.

South Carolina was one of the first 6 states funded in 2002. Starting with year 2003 deaths, SCVDRS collects information from death certificates, coroners' reports and law enforcement for each violent death in SC, which includes suicides. By integrating data from numerous sources, development of an improved understanding of the risk factors and circumstances related to violent deaths is possible. Information such as mechanism, circumstances, and time of day will be available. This data may be used to plan, implement, and evaluate primary prevention programs to reduce the number of these deaths.

Awareness, Intervention, Methodology (A.I.M.)

The AIM (Awareness, Intervention, Methodology) framework identified by the Surgeon General in his 1999, "Call To Action To Prevent Suicide", was used to frame the goals and objectives. The following goals and objectives are adapted from the National Strategy and are included to serve as a guide for future activities.

AWARENESS

Goal #1: Promote Awareness That Suicide Is A Public Health Problem That Is Preventable

Objective 1.1: Develop and implement public information campaigns designed to increase public knowledge of suicide prevention.
Objective 1.2: Establish regular suicide prevention activities such as conferences, public forums, trainings, etc. to foster collaboration and public private partnerships.

Goal #2: Develop Broad-Based Support For Suicide Prevention

Objective 2.1: Increase the number of people/organizations actively involved in some aspect of suicide prevention.
Objective 2.2: Create a broad statewide coalition to advance the goals and objectives of the national strategy and the state plan.
Objective 2.3: Increase the number of faith based groups that adopt policies and programs promoting suicide prevention.
Objective 2.4: Increase the number of professional, voluntary and other groups that integrate suicide prevention activities into their ongoing programs and activities.

Goal #3: Develop And Implement Strategies To Reduce The Stigma Associated With Being A Consumer of Mental Health, Substance Abuse, and Suicide Prevention.

Objective 3.1: Increase the number of people that view mental health and physical health as equal and inseparable components of overall health.
Objective 3.2: Increase the number of people that view mental disorders as real illnesses that respond to specific treatments.
Objective 3.3: Increase the number of people that view consumers of mental health, substance abuse and suicide prevention as pursuing treatment for overall health.
Objective 3.4: Increase the proportion of suicidal persons with underlying mental disorders who receive appropriate mental health treatment.

INTERVENTION

Goal #4: Develop and Implement Community-Based Suicide Prevention Programs

Objective 4.1: Support the creation of public-private partnerships and the development, implementation and evaluation of community prevention plans and programs.
Objective 4.2: Increase the number of public and private schools including colleges and universities that implement evidence-based programs to address student distress and prevent suicide.
Objective 4.3: Increase the number of employers that ensure the availability of evidence-based prevention strategies.
Objective 4.4: Increase the number of correctional facilities, jails, and detention centers that house adults and juveniles with evidence-based prevention programs.
Objective 4.5: Increase the number of elderly, youth, and family and community programs with evidence-based prevention programs.

Goal #5: Promote Efforts To Reduce Access to Lethal Means and Methods of Self-Harm

Objective 5.1: Increase the number of health and safety providers who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.
Objective 5.2: Increase the number of people exposed to public information campaigns designed to reduce accessibility of lethal means in the household.
Objective 5.3: Develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.

Goal #6: Implement Training For Recognition Of At-Risk Behavior and Delivery of Effective Treatment

Objective 6.1: Increase the number of people from the following groups who receive either professional or community trainings in the appropriate assessment of suicide risk treatment delivery and the promotion of protective factors:

- Primary care physicians
- Social workers
- Psychologists
- Counselors
- Clergy
- Correctional staff
- Nurses
- Attorneys
- Teachers and educational administrators
- Community members
- Public safety officials

Goal # 7: Develop And Promote Effective Clinical And Professional Practices

Objective 7.1: Increase the number of clients treated for self-destructive behavior in hospital emergency departments that pursue the mental health follow-up plan.
Objective 7.2: Develop guidelines for the assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers.
Objective 7.3: Develop guidelines for aftercare treatment.
Objective 7.4: Increase the proportion of those who provide key services to suicidal survivors who receive training addressing their own exposure to suicide and the unique needs of suicide survivors.
Objective 7.5: Increase the number of clients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
Objective 7.6: Increase the number of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
Objective 7.7: Develop education programs for family members and significant others receiving care for treatment of mental health and substance abuse disorders with risk of suicide.
Objective 7.8: Incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all federally supported health care programs (e.g. Medicaid, Medicare.

Goal #8: Increase Access to and Community Linkages with Mental Health and Substance Abuse Services.

Objective 8.1: Increase the number of health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.
Objective 8.2: Increase the proportion of communities or organizations with health and/or social service outreach programs for at-risk population that incorporates mental health services and suicide prevention
Objective 8.3: Develop guidelines for mental health screening and referrals of students in schools and colleges.
Objective 8.4: Develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services.
Objective 8.5: Increase the proportion of schools with mental health and substance abuse assessment and management. Define guidelines for mental health screening assessment in treatment of suicidal behavior for adults and juveniles who are incarcerated.
Objective 8.6: Define and implement effective comprehensive support programs for suicide survivors.
Objective 8.7: Develop guidelines for effective response to suicide risk or behavior in managed care and health insurance plans.

Goal #9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness and Substance Abuse in the Entertainment and News Media

Objective 9.1: Promote the accurate and responsible representation of suicidal behaviors, mental illness and related issues in the media.
Objective 9.2: Increase the number of journalism schools that include the recommended guidelines on the reporting of mental illness and suicidal behaviors.

METHODOLOGY

Goal #10: Promote and Support Research on Suicide and Suicide Prevention

Objective 10.1: Increase public and private funding for suicide prevention research with input from survivors, practitioners, researchers and advocates.
Objective 10.2: Establish and maintain a registry of best practice prevention activities for suicide and suicidal behavior.
Objective 10.3: Perform evaluation of new or existing suicide interventions.

Goal#11: Improve and Expand Surveillance Systems

Objective 11.1: Develop standardized protocol for death scene investigations.
Objective 11.2: Regularly collect and provide information on completed suicide and suicidal behavior.
Objective 11.3: Increase the proportion of hospitals that collect uniform and reliable data on suicidal behavior.
Objective 11.4: Produce an annual state report on suicides and suicide attempts integrating data from multi data systems.

South Carolina's Call to Action

In response to the national call to action and the magnitude of the problem in the state, the South Carolina Suicide Prevention Task Force formed in 2003 to begin to examine this issue. In December 2003, members of the newly formed Task Force joined with delegations from 12 other states in New Orleans, La., to participate in a Bi-regional Suicide Prevention Training Conference. The primary goal of the conference was to advance the National Strategy to Prevent Suicide by providing states with up to date research and information to enhance local efforts to address this important public health issue.

The South Carolina Department of Health and Environmental Control formed and currently chairs the South Carolina Task Force. Members of the Task Force represent state government, non-profits, hospitals, suicide survivors, and advocates. The Task Force is concerned about the impact of suicide and suicidal behavior on all South Carolina citizens. During the initial work of the Task Force, committee members selected the following two goals of the National Strategy as the primary focus of their efforts.

- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention, including the formation of a broad statewide coalition

In September of 2004 the Division of Injury and Violence Prevention at DHEC and the SC Public Health Association co-sponsored a SC Violence Prevention Strategic Planning meeting. This meeting brought together state and local stakeholders from law-enforcement, social work, mental health, suicide survivors, public health, education, drug and alcohol abuse services, state and local agencies and non-profit groups. The purpose of the meeting was to give concerned groups access to best practices in violence prevention including suicide. Breakout groups on select topics were conducted, with members of the Task Force participating in the suicide prevention work group. Many of the concerns and recommendations identified by this group are reflected in the state plan.

South Carolina Moving Forward

The South Carolina Plan was created as a living document that is expected to change over time, as new strategies and research are made available and awareness, involvement and funding increase. The Task Force's Suicide Prevention Plan endorses the "National Strategy for Suicide Prevention: Goals and Objectives for Action", and the Institute of Medicine of the National Academies report, "Reducing Suicide, A National Imperative". These two documents represent the latest in suicide research and support a comprehensive and integrated approach to reduce the loss and suffering from suicide and suicidal behaviors across the life span at the national and local levels.

The benefits of a State Plan are to:

- Raise awareness and help make suicide prevention a statewide priority.
- Seek resources to address the issue.
- Provide opportunities to use public-private partnerships and the energy of survivors to engage people who may not consider suicide prevention part of their mission.
- Support collaboration across a broad spectrum of agencies, groups, and community leaders.
- Link information from many prevention programs to avoid duplication and share information about effective prevention activities.
- Direct attention to measures that benefit all people in South Carolina to reduce the likelihood of suicide before vulnerable individuals reach the point of danger.

Recommendations

1. Stakeholders may use The Suicide Prevention Plan as a resource document to create their own strategic plans for action.

2. Community leaders, including task force members, should establish a broad-based, statewide coalition to continue to address goals and objectives such as those contained in the state plan.

3. Encourage commitment of resources and expert technical assistance for developing, implementing and evaluating suicide prevention strategies and plans.

4. State and community leaders should promote statewide availability of prevention and intervention services across populations.

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The problem of suicide has a devastating impact upon South Carolina families and communities–lost children, lost loved ones, lost employees, and lost resources. These losses are preventable.

South Carolina Suicide Prevention Task Force

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Resource Information

National Organizations

National Crisis
Phone Number: 1-800-Suicide (1-800-784-2433)

American Association of Suicidology
http://www.suicidology.org

American Foundation for Suicide Prevention
http://www.afsp.org

Suicide Prevention Resource Center
http://www.sprc.org

Suicide Prevention Advocacy Network USA
http://www.spanusa.org

National Organization of People of Color Against Suicide
http://www.nopcas.com

National Strategy for Suicide Prevention
http://www.mentalhealth.org/suicideprevention

Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)
http://cdc.gov/ncipc/dvp

Children's Safety Network (CSN)
http://www.edc.org/HHD/csn

South Carolina Organizations

National Alliance for the Mentally Ill, South Carolina
http://www.namisc.org

Mental Health Association in South Carolina
http://www.mha-sc.org/

S.C. Department of Mental Health
http://teen-matters.com/suicide.html

South Carolina Department of Health and Environmental Control
www.scdhec.net